Let's get talking

A suite of talking therapy tools from Te Pou

Te Pou o Te Whakaaro Nui

Assessment

How to match talking therapies to peoples' needs

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This guidance document is part of a suite of tools developed by Te Pou o Te Whakaaro Nui to support mental health and addiction services increase access to evidence-based talking therapies using a stepped care approach. It aims to support best practice in the field of therapy and its delivery.

The *Let's get talking Assessment* tool provides clinicians and services with guidance on how to assess and match people to different levels of talking therapies using a stepped care approach. It also facilitates review of progress to enable movement between levels of therapy according to peoples' needs.

The tool has been designed for use in both primary and secondary health care services, and may be adapted for your service. It recommends factors to be included during the assessment and matching to a therapy level. The process does not set strict criterion and needs to be flexible and responsive to the needs of the person and their family and whānau. It assumes that practitioners have the assessment and therapeutic skill necessary for this.

It is important to note that this tool is intended to be inclusive for use by Māori, Pasifika, Asian and other ethnic groups, services and practitioners. The processes may need to be adapted to suit the cultural needs of a specific ethnic group. Included is an example of a Māori model of assessment which can be used in mental health and addiction. Tāngata whai ora and their family and whānau are acknowledged throughout this document.

This document refers primarily to services for the adult population although there are stepped care models relevant to the youth population that in part reflect the model used here. Please refer to the Werry Centre for information on infant, child and adolescent mental health and/or alcohol and other drug problems.

The following are a list of tools which complete the *Let's get talking* toolkit available on the Te Pou website.

- Introduction: A stepped care approach to talking therapies
- Planning: Develop or extend talking therapies delivery
- Skills survey: Identify strengths and areas for development in talking therapies delivery
- Assessment: How to match talking therapies to peoples' needs
- Therapy: A guide to evidence-based talking therapies
- Review: Progress and outcome measures to support talking therapies delivery
- Practice support: Competencies, training and supervision for talking therapies delivery

What is stepped care?

Stepped care is an approach which uses the least intrusive care to meet presenting needs, and enables people to move to a different step (level) of care as their needs change.[1] In psychological and talking therapies, stepped care aims to optimise clinical effectiveness and cost-effectiveness of therapy, through a systematic approach of matching the right type and intensity of therapy to a person's needs.[2]

Stepped care involves:

1 providing different types of therapies of varying intensity (i.e. on different steps) to meet different levels of complexity and severity

2 processes for matching a person to the step that will best meet their needs

3 identifying when a person's needs change or are not being met at their current step, and changing steps (up or down) accordingly.

1 - Mental Health Commission. (2012). *Blueprint II: How things need to be.* Wellington: Mental Health Commission.
2 - Haga, D. (2000). Introduction to the special section on stepped care models in psychotherapy. *Journal of Consulting and Clinical Psychology, 68 (4)*, 547-548.

Assessing needs and matching to therapy

Within a stepped care approach, assessing a person's needs and matching to a level of talking therapy is based on the review of a range of factors. These may change over time so it is advisable not to base the review on rigid criteria.

Factors to consider include:

- cultural issues
- identification of presenting problem and level of distress
- mental health and addiction assessment and screening
- person's strengths, choices and goals
- clinical and therapist opinion
- issues of risk
- co-existing problems
- involvement of family, whānau and other resources, for example, social and community services
- evidence-based talking therapy and availability of resources.

Cultural issues

Where there are cultural needs and preferences, a discussion of these with the person and/or their spokesperson is important. Referral for a cultural assessment may assist with matching to the appropriate therapy or provider. Whānau involvement may be included from the start as they can be part of sustaining and supporting change. It is recommended that the practitioner seek cultural advice and guidance as appropriate.

Further information on talking therapies for different cultural groups is available in the Talking Therapies guides on the Te Pou website.

Presenting problem and level of distress

The person's presenting problem(s) and/or disorder(s) and level of distress need to be understood and clarified. Assessment will determine the appropriate level of therapy.

In primary health care, such as GP practices or whānau ora providers, screening may result in brief interventions or referral to a specialist service for further assessment. The assessed level of distress will inform the urgency and intensity of a therapy intervention. It is important to understand distress through a wider lens (see 'Co-existing problems' below). Cultural assessment will need to be considered where appropriate.

Mental health and addiction assessment and screening

Assessment and screening can be carried out through brief verbal discussion, formal assessment tools or full specialist assessment. It is recommended that all people presenting with mental health problems should be screened for substance use. Assessment needs to take into account other potential causes of low mood or depressive symptoms, for example, hypo-thyroidism, Parkinson's disease, chronic pain, brain injury or other undiagnosed physical illnesses. The cultural appropriateness of screening and assessment tools requires consideration to ensure understanding and accuracy of assessment. The tools may not have normative information for some populations, but may be a useful place to start.

Strengths, choices and goals

The person's strengths, choices and goals are to be included to improve their problem(s) and distress, and to bring about positive changes in their lives. These need to be respected as they help to direct the choice of support and therapy and may influence therapy effectiveness. This can include:

- whether or not they are referred for further support and therapy
- the type of support and therapy (with reference to previous experience of help)
- the practitioner and the service that they see
- when, where and how they want to receive therapy.

Preferences regarding ethnicity, religion, gender and other personal beliefs also need to be considered. The person's strengths, skills and knowledge support their wellbeing and resilience. Further factors that may be relevant are literacy level, cognitive impairment, presence of disability and age of the person. Good engagement and a positive therapeutic relationship between the practitioner and the person is one of the best predictors of successful outcomes. This is further improved by mutually agreed upon goals and the ongoing feedback the person gives regarding any support and therapy they receive.[3]

3 - Miller, S.D., Duncan, B.L., Brown, J., Sorrell, R. & Chalk, M.B. (2006). Using Formal Client Feedback to Improve Retention and Outcome: Making Ongoing, Real-time Assessment Feasible. *Journal of Brief Therapy*, 5 (1), 5-22.

Clinical and therapist opinion

The clinical and therapeutic opinion and recommendations of the assessing and/or treating practitioner needs to be used in conjunction with information from any screening and assessment measures to determine the type and level of therapy. Information from other teams or practitioners may also provide useful opinion. Scores on screening and assessment tools are only one source of information. It is important not to solely rely on such measures when matching to a level of therapy, such as, when working with different cultural groups.

Issues of risk

Where indicated, risk to the health of the person needs to be assessed. Health risks may be the deterioration of mental health, a problem with alcohol or other substances and/or gambling, risk of self-harm or suicide or harm to others, or physical health problems. This may require further assessment and consultation with specialist clinicians. Crisis intervention and stabilisation of mental health or addiction issues may be needed before referral for therapy.

Co-existing problems

Practitioners need to consider co-existing problems that may be contributing to problems or distress. These may require assessment and referral to other services. Issues can include mental health problems, alcohol or substance use and/or gambling problems, long term physical illness, pain, sleep disorder, disability and cognitive impairment. The presence of trauma and/or interpersonal violence needs to be assessed for. These may impact on the person's wellbeing to increase their level of distress and complicate their path to recovery. Broader social determinants of mental health may include family responsibilities, stress, poverty, unemployment, housing, social or cultural dislocation and lack of a meaningful role.

Te Pou and Matua Raki have developed a comprehensive set of guidance and resources to assist practitioners when working with people with co-existing mental health and addiction problems.[4]

Engagement with family, whānau and significant others

Engagement with family and whānau is important as they provide ongoing support for wellbeing, recovery, risk management and support for children. They can support the person through the process of treatment, including follow-up. Family and whānau can also provide valuable insight and information to help clarify a person's distress and problem(s). They may also be the spokespeople for the person. Family and whānau may be experiencing distress and it may be relevant to link them to appropriate services to support their own wellbeing.

Note: Confidentiality issues. The person has a choice as to whether the service can involve and/or consult with family, whānau and significant others. Where there is clear risk to the person or others, family and whānau may need to be involved.

Evidence-based talking therapy

The level of intervention will indicate the appropriate support or therapy for a person. Early problems or distress can be supported through self management and brief intervention (BI). For more intensive therapy it is recommended that practitioners refer to an evidence-based talking therapy that has been identified as being effective for addressing the person's mental health and/or addiction related problem. This may be available through a package of care (POC) often provided by a primary health organisation (PHO), non government organisation (NGO), or private practitioners in the community. Where the person has a complex and/or severe presentation, a comprehensive assessment, formulation and treatment plan is provided by a specialist practitioner to recommend the best approach for their needs. A Scottish document *The Matrix* (NHS Scotland, 2011)[5] summarises the current evidence base for psychological or talking therapies and is a useful resource for identifying diagnosis specific evidence based therapies.

Note: When considering referral to an emerging talking therapy that has not yet gained a substantial base of evidence for effectiveness, it is recommended that the practitioner seek appropriate specialist advice to make an informed decision as to whether or not to proceed, as the intervention may still be culturally relevant and useful.

Availability of resources will influence what therapy is offered. Barriers include waiting lists, availability of appropriate practitioners, funding, and the type(s) of therapy a service provides. When therapeutic interventions at more intensive levels are not immediately available, the person may benefit from an intervention or therapy of less intensity in the meantime. For example, a person who needs to wait for individual therapy for post-traumatic stress disorder may gain considerable benefit in the interim from attending a group teaching distress tolerance or skills in cognitive behavioural therapy (CBT) and anxiety management.

Any previous therapy that the person has received and a practitioner's competency level in a therapy modality needs to be known as it may influence the outcome of therapy. Medication may need to be discussed as part of a treatment plan to complement therapy and/or when access to therapy is limited.

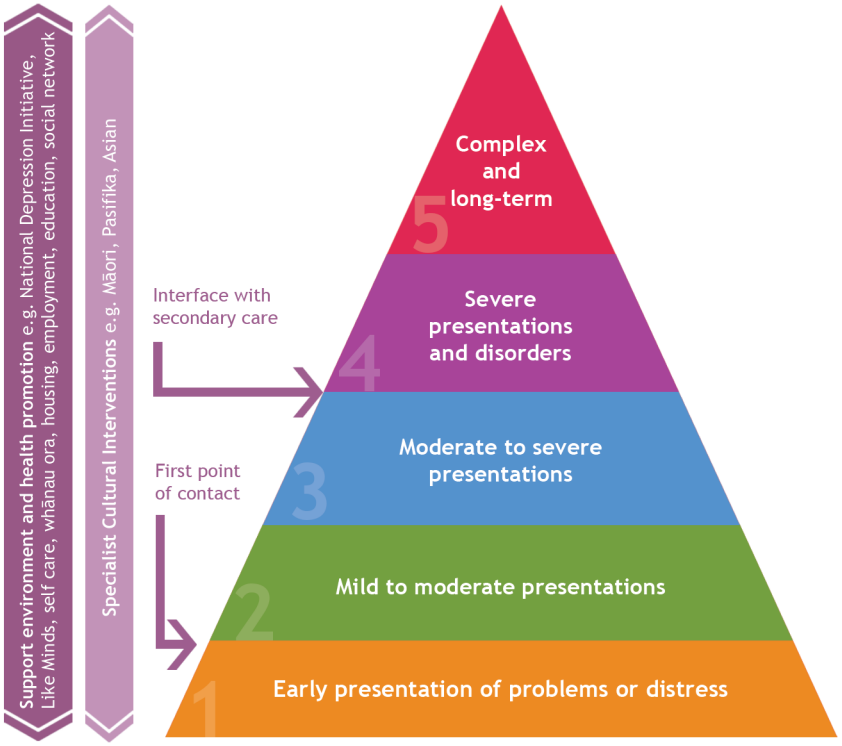
4 - Te Pou and Matua Raki resource documents www.tepou.co.nz/improving-services/co-existing-problems/cep-roadmap

5 - NHS Education for Scotland. (2011). *A guide to delivering evidence-based psychological therapies in Scotland. 'The Matrix - 2011'*. Scotland: National Health Service: Education for Scotland.

Guide to therapy and levels in stepped care

(Te Pou, 2014)

This section outlines the core clinical indicators for a person experiencing problem(s) and/or disorder(s) at different levels of stepped care. It gives examples of the types of support and talking therapies that can address these.[6] It can also be used to guide assessment to ensure a person is matched to the right level and type of talking therapy.



	Service Level	Examples	Who
5	Highly specialised	Specialist psychological and multi-systemic therapies.	Psychologists, therapists, psychiatrists and other health professionals with specialised training in psychological therapies.
4	Specialist	Specific structured therapies including CBT, dialectical therapy (DBT), psycho-therapy, family therapy.	Mental health and addiction clinical staff (any profession) trained in evidence-based therapies.
3	High-intensity	Evidence based therapies such as CBT, interpersonal therapy (IPT), acceptance and commitment therapy (ACT), solution focused therapy.	PHOs, NGOs, primary health care, and community practitioners.
2	Low-intensity	Brief evidence based therapy such as guided self-help, cognitive behaviour therapy (CBT), e-therapy, motivational interviewing.	Primary health care and community practitioners.
1	Early identification of vulnerability	Brief interventions including active monitoring, education, information, self-care.	GPs and other health care professionals who have first contact with service users.

6 - Te Pou o Te Whakaaro Nui. (2009). *A Guide to talking therapies in New Zealand.* Auckland: Te Pou o Te Whakaaro Nui.
NICE. (2011). *Common mental health disorders: Identification and pathways to care.* NICE clinical guideline 123. Retrieved from www.nice.org.uk/CG123

Guide to therapy and levels of stepped care (Te Pou, 2014)

LEVEL 1 - Early presentation of problems or distress: monitoring and brief intervention	
Presentation	Assessment may identify that the person has emotional, psychological or social problems such as: • transitional issues or difficulties – relationship issues, bereavement, work stress • some level of distress (Kessler 10 score in the mild range 20–24) • no more than slight impairment in psychological/social functioning • a long term physical condition • no formal diagnosis or clear disorder.
Intervention	First response to problems is in primary care, at a GP practice level. The use of knowledge and skills in mental health and addictions is recommended to identify and monitor the person's presentation of vulnerability, and to build resilience. Wellbeing is supported through self-management and provision of brief interventions (BI), for typically 1-3 sessions, such as: • information/education/self-care strategies • enhancing strengths to build resilience • phone support - Lifeline, Alcohol/Drug helpline • extended consultations • referral to support/self-help groups in the community • access to community resources - financial, housing, education, social services • support via a whānau ora model if applicable.
By whom	Provided in primary care by health clinicians and practitioners, whānau ora and support workers.

LEVEL 2 - Mild to moderate presentations: low intensity evidence-based therapy	
Presentation	Assessment identifies mental health and/or addiction problems and risk factors for the person such as: • persistent symptoms that present in the mild to moderate range • a recognised problem or disorder • mild to moderate distress (Kessler 10 score in mild range 20-24) • impairment in psychological and social functioning, and wellbeing • problems in areas of self-care, relationships or occupation.
Intervention	At primary care level, practitioners use knowledge and skills in mental health and addiction to actively engage the person and link them to an appropriate intervention. The person may recover with brief therapy typically ranging from 4 to 8 sessions[7] such as: • guided self-help, cognitive behavioural therapy (CBT), motivational interviewing (MI) • e-therapies - www.depression.org.nz, www.moodgym.anu.edu.au/welcome • skills groups such as stress and anxiety management • educational, support and cultural groups • referral to community services including financial, housing, education, social services.
By whom	Provided in primary care by appropriately trained and supervised health clinicians and practitioners.

7 - NICE. (2011). *Generalised anxiety disorder and panic disorder (with or without agoraphobia) in adults: Management in primary, secondary and community care.* NICE clinical guideline 113. Retrieved from www.nice.org.uk/CG113

NICE. (2009). *Depression in adults: The treatment and management of depression in adults.* NICE clinical guideline 90. Retrieved from www.nice.org.uk/CG90

IAPT. (2013). *Which Talking Therapy for Depression?* Department of Health (UK). Retrieved from www.iapt.nhs.uk

Te Pou o Te Whakaaro Nui. (2012). *Talking Therapies: Where to Next?* Auckland: Te Pou o Te Whakaaro Nui.

LEVEL 3 - Moderate to severe presentations: high intensity evidence-based therapy	
Presentation	The person has a mental health and/or addiction problem or disorder[8] such as: • depression, anxiety, post-traumatic stress, substance use • distress (Kessler 10 score in moderate range 25-29) • problems with psychosocial functioning and/or: • may not have responded to an earlier level of treatment • may have co-existing problems (mental health, addiction, physical health, disability, social issues) • may have a history of complex and/or long-term problems.
Intervention	At this level, the person is best supported with high intensity evidence-based therapies, typically ranging from 12-20 sessions[9] such as: • CBT, solution-focused brief therapy (SFBT), psychotherapy, acceptance and commitment therapy (ACT) • group therapy to develop skills in distress tolerance and managing emotions • support from family and whānau and peer support services • referral to community services including financial, housing, education, social services • medication may also be prescribed at this level.
By whom	Trained and supervised practitioners, therapists and psychologists in primary care in PHOs, NGOs, and private community services.

8 - American Psychiatric Association. (2013). *Diagnostic and Statistical Manual of Mental Health Disorders* (5th ed.) American Psychiatric Association. Washington, DC: American Psychiatric Association.

9 - NICE. (2009). *Depression in adults: The treatment and management of depression in adults.* NICE clinical guideline 90. Retrieved from www.nice.org.uk/CG90.

NICE. (2011). *Common mental health disorders: Identification and pathway to care.* NICE clinical guideline 123. Retrieved from www.nice.org.uk/CG123

Te Pou o Te Whakaaro Nui. (2012). *Talking Therapies: Where to next?* Auckland: Te Pou o Te Whakaaro Nui.

LEVEL 4/5 - Severe and complex presentations: high specialist evidence-based therapy	
Presentation	*In secondary care Level 4 is considered to be high intensity community based services and Level 5 is considered to be high intensity inpatient services.* The person may present with: • severe, complex and/or long-term issues/disorders with high needs • high levels of distress (Kessler 10 score in high range 30-50) • co-existing problems (mental health, addiction, physical health, disability, and social issues) • a recurrent presentation (and/or previous treatment has been unsuccessful) • a presentation considered to be a-typical and/or psychotic • risk to self or others (including any previous risk) • scores on relevant and specific screening measures indicate the severe range.
Intervention	This level requires comprehensive psychological and/or psychiatric assessment, and an integrated formulation to plan the therapy intervention. • Immediate, acute and crisis intervention may be indicated. • Psychometric assessment is required for specific diagnoses, disorders or neuro-psychological problems. • The type and duration of specialist therapy is tailored to the needs of the person. • Therapy may include CBT, interpersonal therapy (IPT), psychotherapy, dialectical behaviour therapy (DBT), family therapy, trauma therapy. • Medication and other treatment may also be recommended. • Inpatient and residential treatment may be indicated.
By whom	By psychologists and highly trained and supervised therapists and specialists in secondary care in community based or inpatient services.

Example: Matching to therapy (Te Pou, 2014)

Name	Date	Clinician
Address	Ethnicity	Service
Problem(s)/disorder(s)		
Person's goals and preferences		
Level of distress	NONE LOW HIGH	
Level of risk/urgency	NONE LOW HIGH	
Information from mental health/addiction screens		
Co-existing problems		
Information from family and whānau/other sources		
Culturally relevant information		
Level of therapy (include reasons and availability)	1 2 3 4 5	
Therapy e.g. CBT, MI, skills training, problem solving therapy (include reasons)		
Review Date		

Example: Assessment of mental health and wellbeing for matching to therapy

Adapted from the Te Whare Tapa Whā and Meihana models, and the assessment form from Manawanui Oranga Hinengaro, Mental Health Service for Māori, Auckland DHB.

Name	
Address	
Date	Ethnicity
Assessed by	
Service	
Taha hinengaro Psychological wellbeing, the capacity to communicate, understand, think and feel. This also includes strengths and risks to mental health and addiction.	
Taha tinana Capacity for physical health and good functioning, for example, mobility and pain, mind and body links and feelings about themselves.	
Taha whānau Sense of belonging and of purpose, the relevance of family and whānau, support networks and social participation.	
Taha wairua Capacity for engagement with spiritual values, people and place including feelings of worth, identity and whakamā (embarrassment, shame or indignity).	
Taiao The impact of the physical environment including housing, employment, education, resources to enhance recovery.	
Iwi katoa Relationship to wider societal context including values, laws, beliefs.	
What do you want/need to assist your wellbeing?	
How would you (and your family and whānau) like to participate in your wellbeing?	
Any other comments you would like to make?	
Assessment of mental health and wellbeing Based on problems, strengths, needs and choices.	
Recommendations Level of health care needed and therapeutic interventions that would be useful, for example, talking therapies, social and community resources, medical.	
Plan and review	

Assessment and screening

Assessment and screening can be completed at different levels in health care, from brief screening questions in primary care through to comprehensive assessment in secondary care. The New Zealand clinical guidelines recommend a two stage screening process to identify a range of mental health and addiction problems in primary healthcare settings.[10] Brief screening can be used where indicated or with all new consultations.

Stage 1: Initially health professionals can use 1-2 validated verbal screening questions to identify potential problems with depression, anxiety and substance use.

- "During the last month have you been feeling down, depressed or hopeless?"
- "During the last month have you often been bothered by having little interest or pleasure in doing things?"[11]

For anxiety, ask questions when a person is seeking reassurance about a chronic physical health problem or somatic symptoms and/or repeated worrying.[12]

Where responses are positive, the person should then be asked whether they want help with the issue at that time.

Stage 2: Where an issue is indicated and the person wants help, further exploration of the issue should occur, which may involve the use of more formal validated screening tools.

Examples of validated screening tools available for use in both primary and secondary health services:[13]

- Generalised Anxiety Disorder Assessment Tool (GAD-7)
- Patient Health Questionnaire for Depression (PHQ-9)
- Alcohol Use Disorders Identification Test (AUDIT)
- Kessler Psychological Distress Scale (K10)
- Case Finding and Help Assessment Tool (CHAT/e CHAT)
- Early Intervention Gambling Health Test (EIGHT)
- Alcohol, Smoking and Substance Involvement Screening Test (ASSIST)

Note: Research has shown that screening tools alone do not improve outcomes.

Cultural appropriateness

Screening tools are ideally validated with the populations they are used with. Attentive and appropriate use of screening tools with, for example, Māori, Pasifika and Asian communities, can be useful to enhance rapport and begin therapeutic conversations.

Co-existing problems

Screening for co-existing problems in primary care settings may enable early recognition which has the potential to improve health outcomes. Screening tools with integrated assessment may address several issues at once, for example, Kessler 10 and eCHAT, or screening tools for alcohol and other drugs, smoking and gambling.[14]

10 - New Zealand Guidelines Group. (2008). Identification of common mental disorders and management of depression in primary care: An evidence-based best practice guideline. Wellington: New Zealand Guidelines Group.

11 - NICE. (2009). *Depression in adults: The treatment and management of depression in adults.* NICE clinical guideline 90. Retrieved from www.nice.org.uk/CG90.

12 - NICE. (2011). *Generalised anxiety disorder and panic disorder (with or without agoraphobia) in adults: Management in primary, secondary and community care.* NICE clinical guideline 113. Retrieved from www.nice.org.uk/CG113

13 - NZ Guidelines Group. (2008). Identification of common mental disorders and management of depression in primary care: An evidence-based best practice guideline. Wellington: New Zealand Guidelines Group.

14 - Matua Raki. (2011). *Screening, Assessment and Evaluation (alcohol and other drugs, smoking and gambling).* Wellington: Matua Raki.

Example: Brief screen for intervention/therapy

With acknowledgement to Procare PHO, Auckland, 2014

Level of Concern	Assessment		Level of Urgency	
		Kessler10	**LOW**	**HIGH**
	HIGH	30-50	Referral to secondary mental health or addiction services (MH/AOD) **OR** Referral to primary health based high intensity MH/AOD intervention **AND/OR** Referral for assistance with Social Determinants of Health if indicated.	Referral to crisis team/acute inpatient service or secondary MH/AOD services **OR** Referral to primary health based high intensity MH/AOD intervention **AND/OR** Referral for assistance with Social Determinants of Health if indicated.
	MEDIUM	25-29	Referral for primary health based medium-low intensity MH/AOD interventions **OR** Referral for primary health based group interventions **OR** Self-management strategies (e-therapy, bibliotherapy, Green Prescription, etc.) with support and active follow-up **AND/OR** Referral for assistance with Social Determinants of Health if indicated.	Referral to secondary MH/AOD services if most appropriate **OR** Referral to primary health based medium to high intensity MH/AOD intervention **AND/OR** Referral for assistance with Social Determinants of Health if indicated.
	LOW	20-24	Self-management strategies (e-therapy, bibliotherapy, Green Prescription, etc.) with support and review as appropriate **OR** Referral for primary health based group interventions **OR** Referral for low-medium level counselling/brief intervention **AND/OR** Referral for assistance with Social Determinants of Health if indicated.	Self-management strategies with support and active follow-up **OR** Extended consultation with view to clarification and intervention **OR** Referral for low-medium level counselling/brief intervention **OR** Referral to primary health based group interventions **AND/OR** Referral for assistance with Social Determinants of Health if indicated.

Notes:

1 The Kessler 10 ranges should be considered as a guide only. High scores on key items or subjective levels of concern that are inconsistent with the Kessler score should be taken into consideration. A useful approach may be to act at the higher of the person's reported level of concern or the Kessler level. Note that the Kessler score may under-represent the distress associated with conditions other than depression.

2 The PHQ9 may be used as an alternative measure.

3 Some patients, for example, those suspected of having diagnoses such as Borderline Personality Disorder of moderate severity/risk, may be best managed by an integrated mental health team rather than by individual practitioners in a primary care setting.

4 For information on social determinants of health refer to nhc.health.govt.nz/system/files/documents/publications/det-health.pdf

Brief interventions (BI)

Brief interventions can be provided for people with mild to moderate levels of problems, whereas those with more severe or complex problems are referred to specialist services (Matua Raki, 2012).[15] Brief intervention, as discussed here, refers to first responses to presentations at lower levels of stepped care. This differs from brief therapy which refers to targeted higher intensity interventions that can be delivered at higher levels of stepped care.

BI appropriate for primary health care settings commonly include:

- giving people feedback and raising awareness
- building positive options for the person aimed at enhancing wellbeing and resilience
- assessment of motivation and readiness for change
- problem-solving, goal setting and/or relapse prevention
- education for the person (and family and whānau) about the problems/disorders and treatment options
- advice about addressing lifestyle risk factors, for example, sleep hygiene, relaxation strategies, self-care
- cognitive behavioural based self-help resources (either guided by a professional or not)
- behavioural activation techniques
- active monitoring of symptoms to identify whether more intensive treatment is required
- short courses of talking therapy.

Common BI used for mild to moderate anxiety, depression, problem gambling and substance use problems include raising the person's awareness and understanding of the issue, encouraging them to make lifestyle changes and monitoring progress.

The evidence for the effectiveness of BI with anxiety and depression is in the emerging stages. Currently the evidence is strongest for brief interventions for people with alcohol use problems and supports the use of opportunistic screening and referral to treatment for the common mental health and addiction issues among adults (SAMHSA 2011).[16] Examples of resources that are available include:

- Decision support tools and websites such as www.bpac.org.nz, www.primarymentalhealth.org.nz
- National Depression Initiative www.depression.org.nz
- NICE guidelines for depression and anxiety (2009, 2011)[17]
- eCHAT
- Brief Intervention Guide: Addressing risk and harm related to alcohol, tobacco, other drugs and gambling (Matua Raki, 2012)[18]
- ABC smoking programme

15 - Matua Raki. (2011). *Screening, Assessment and Evaluation (alcohol and other drug, smoking and gambling).* Wellington: Matua Raki.

16 - Substance Abuse and Mental Health Services Administration. (2013). *Systems-Level Implementation of Screening, Brief Intervention, and Referral to Treatment.* Technical Assistance Publication (TAP) Series 33. Retrieved from www.samsha.gov

17 - NICE. (2011). *Generalised anxiety disorder and panic disorder (with or without agoraphobia) in adults: Management in primary, secondary and community care.* NICE clinical guideline 113. Retrieved from www.nice.org.uk/CG113

NICE. (2009). *Depression in adult: The treatment and management of depression in adults.* NICE clinical guideline 90. Retrieved from www.nice.org.uk/CG90

18 - Matua Raki. (2012). *Brief Intervention Guide: Addressing risk and harm related to alcohol, tobacco, other drugs and gambling.* Wellington: Matua Raki.

Example: Brief interventions in primary health services[19]

Range of screening and brief interventions	Screening	Brief intervention (BI)		Low intensity therapy	Referral to high intensity therapy
	• Single questions • Screening tools	• Self-managed • Single 5-10 min conversation • Feedback from screening • Advice • Leaflet • Inform of self-help resources • Monitoring	• Supported BI • 1-3 sessions • Motivational lifestyle counselling • Guided self-help • Education and skills group • E-therapy • Monitoring	• 4-8 sessions, up to 60 mins • Talking therapies e.g. cognitive behavioural therapy, motivational interviewing, problem-solving therapy, group therapy	• Refer to: PHOs, NGOs, secondary or tertiary mental health and addiction services
Workforce involved	GPs, practice nurses and other trained health care workers such as NGO, whānau ora workers, support workers, mental health and addiction practitioners	GPs, practice nurses and other trained health care workers such as NGO, whānau ora workers, support workers, mental health and addiction practitioners	GPs, practice nurses and other trained health care workers such as NGO, whānau ora workers, support workers, mental health and addiction practitioners	Provided in primary care by appropriately trained and supervised health practitioners	Mental health and addiction practitioners and specialists
Examples of current initiatives	• e-Chat screening tool • PHQ 9 • Kessler 10	• ABC alcohol program • CALM online resources • National depression websites e.g. www.depression.org.nz	• Stress management in primary care • Intervention (ultra-brief intervention) • Brief CBT • Smoking cessation	• PHO funded packages of care • Beating the Blues® • BPAC electronic decision support tool for depression	• National directory of AOD services • DHB specialist interventions • Gambling Helpline

19 - Adapted from tables in Ministry of Health (2010) and the Alcohol Academy (2013).

Ministry of Health. (2010). *Towards optimal mental health and alcohol and other drug care in the new primary care environment: A draft guidance paper.* Unpublished report. Wellington: Ministry of Health.

The Alcohol Academy. (2013). Clarifying alcohol brief interventions: 2013 update. Retrieved from www.alcoholacademy.net

Review and change of therapy level

A regular review of therapy will assess how much progress has been made against agreed goals. Reviews also occur where there is improvement, unplanned change, deterioration or increased risk.

Progress review will determine if the person is:

- continued at the same level
- stepped up or down a level
- discharged from therapy if it is completed
- referred to another type and level of therapy
- referred to another therapist or service.

The review of therapy progress is to assess:

- if the person's goals for support or therapy have been met
- symptom relief
- a decrease in distress
- an increase in wellbeing
- reasons for any changes.

A change in level may occur even if factors used for matching to a level of therapy are unchanged. A review may be brief or comprehensive depending on the level of problem or service.

A collaborative approach may include input from the person receiving therapy, appropriate family and whānau input, information from other relevant practitioners and results of assessments and outcome measures. Recommendations can be made and barriers to progress discussed. Decision making may be influenced by factors that are not always consistent with best practice[20] such as availability of therapy resources or where a person has been in therapy for too long without apparent gains and despite the need for change.

Outcome measures are used to review therapy progress for mental health and addiction problems. Recent evidence[21] indicates that most gains in therapy are made during the first sessions where early treatment responses are highly indicative of overall outcomes. This is typically seen in the first three sessions. The quality of the therapeutic relationship is one of the best predictors of an effective therapy outcome if rated by the person using the service. Feedback from the person to the practitioner is likely to enhance effectiveness of the therapy. Practitioners need to be encouraged to measure treatment outcomes and adjust the therapy on an ongoing basis. Tools also need to be evaluated for cultural appropriateness. Please refer to *Let's get talking Review* for further information on outcome measures.

Examples of progress measures which are client rated and specific to talking therapies are the Outcome Rating Scale (ORS) which can be used over time to assess progress in therapy and Session Rating Scale (SRS)[22] used to measure the quality of the therapeutic relationship.

20 - Delgadillo, J., Gellatly, J., Stephenson-Bellwood, S. (2013). Decision Making in Stepped Care: How Do Therapists Decide Whether to Prolong Treatment or Not? *Behavioural and Cognitive Psychotherapy*, 1-14.

21 - Miller, S.D., Duncan, B.L., Brown, J., Sorrell, R. & Chalk, M. B. (2006). Using Formal Client Feedback to Improve Retention and Outcome: Making Ongoing, Real-time Assessment Feasible. *Journal of Brief Therapy, 5 (1),* 5-22.

Hansen, N.B. & Lambert, M.J (2003). An evaluation of the dose-response relationship in naturalistic treatment settings using survival analysis. *Mental Health Services Research, 5(1),* 1-12.

22 - Miller, S.D., Duncan, B.L., Brown, J., Sorrell, R., & Chalk, M. B. (2006). Using Formal Client Feedback to Improve Retention and Outcome: Making Ongoing, Real-time Assessment Feasible. *Journal of Brief Therapy, 5 (1),* 5-22.

Example: Therapy review (Te Pou, 2014)

Name	Service	Clinician
Address	Ethnicity	Review date
Problems/disorders		
Current therapy	Therapy type	Therapy level 1 2 3 4 5 / Number of sessions

Information from

Person / family and whānau			
Progress and outcome measures			
Review by therapist			
Change to therapy	Therapy type	Therapy level 1 2 3 4 5	Completed
Comments/reasons			
Next review date			

A suite of talking therapy tools from Te Pou

Te Pou
o Te Whakaaro Nui